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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2130 CERTIFICATE OF DEATH

02124

Reg. Dist. No. 251

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Sudlersville</u>		<u>3 mo.</u>		TOWN <u>Rural Sudlersville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>GENE</u> (Middle) <u>WAYNE</u> (Last) <u>CLOUGH</u>				<u>2</u> <u>27</u> 19 <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>11/5/55</u>	<u>3</u>	<u>21</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>None</u>			<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John J. Clough</u>				<u>Margaret Schofield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>John Clough, Sudlersville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Probab, Bronchial Py-monia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Bronchitis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>clay fever</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>2</u>		<u>None</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>None</u>		<u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>2</u>		<u>2</u>		<u>None</u>			
22. I hereby certify that I attended the deceased from <u>Dead on arrival, Queen Anne</u>, that I last saw the deceased alive on <u>2/27/56</u>, 19 <u>56</u>, and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. D. Dupont</u>				ADDRESS (Street, city, town, state) <u>Sudlersville, Md.</u>		DATE SIGNED <u>2/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/28/56</u>		<u>Semperville</u>		<u>Semperville, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-28</u>		<u>Edgar L. Lane</u>		<u>J. E. Boulaie</u>		<u>Greensboro, Md.</u>	

2080224375

CERTIFICATE OF DEATH

1. DEATH REPORTED BY (Name of Person)

MARYLAND
COUNTY OF BALTIMORE

*Robert, Benjamin
J. 1956*

Robert

BUREAU V. S.

MAR 5 1956

RECEIVED

Robert

Robert

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02125

2131 CERTIFICATE OF DEATH

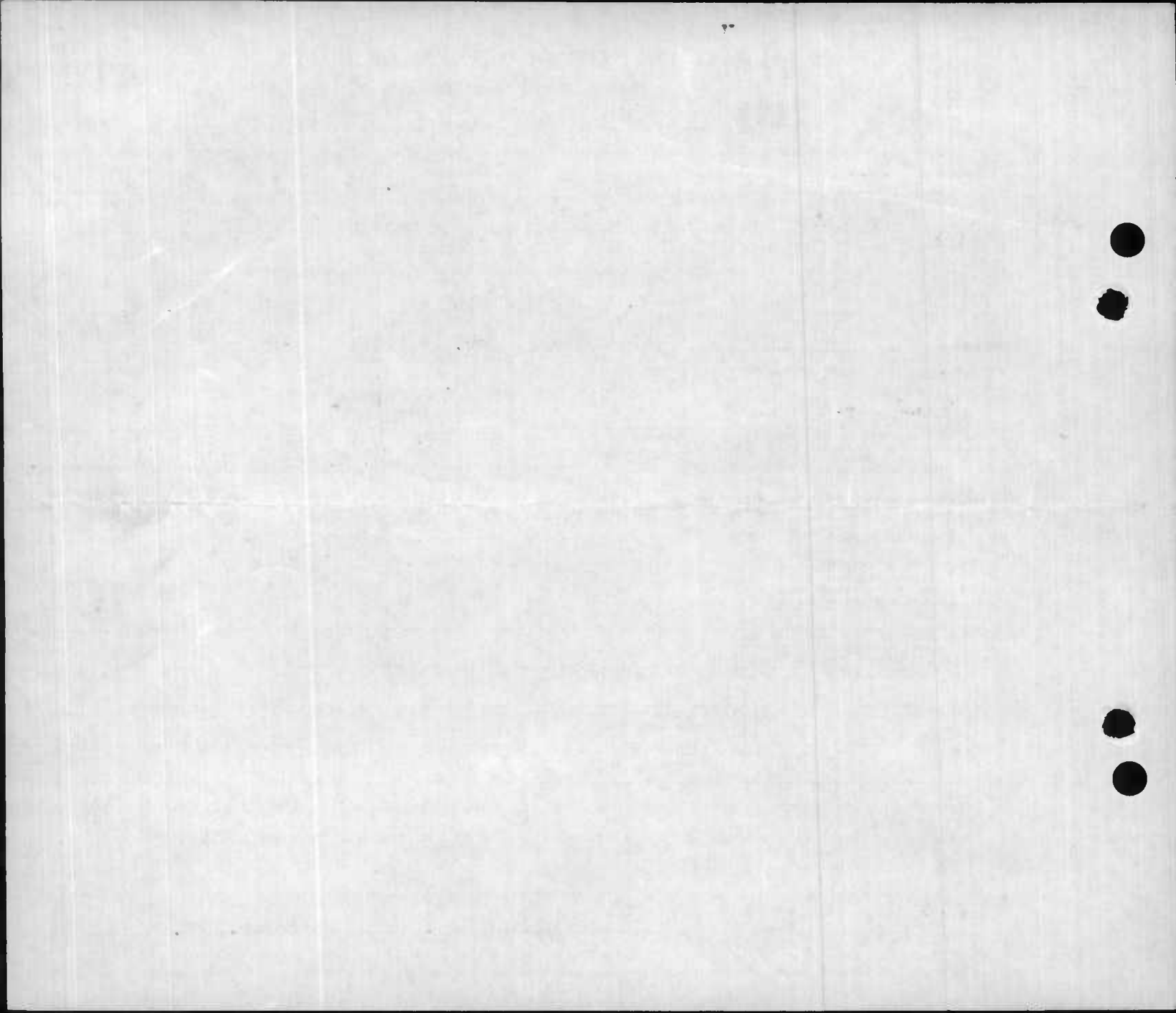
Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Grasonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>SARAH</u> (Middle) <u>V.</u> (Last) <u>DRECHSLER</u>	4. DATE OF DEATH	(Month) <u>Feb.</u> (Day) <u>19.</u> (Year) <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 18, 1873</u> 9. AGE last birthday <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Mfg</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>John McKewen</u>		14. MOTHER'S MAIDEN NAME <u>Alice Buckey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-22-8674</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Chas. E. Hurley - Grasonville, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>2 hr.</u>
Antecedent cause(s) (b) <u>Hypertension - Anteriorly C-V Disease</u>			<u>? yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
HOMICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>55</u> , to <u>Feb</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>56</u> , and that death occurred at <u>8:49</u> a.m., from the causes and on the date stated above.			
SIGNATURE <u>Irvin D. Hoyt MD</u>		ADDRESS <u>Queenstown Md.</u> DATE SIGNED <u>2/19/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/22/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		LOCATION (City, town, or county) <u>Balto., Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>Feb 21, 1956</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Thos. J. Lickens & Sons - Balto.</u>		ADDRESS <u>17 E. ... Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

02126

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

2132

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>near Stevensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Stevensville RZN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>John</u> (Middle) <u>William</u> (Last) <u>Groves</u>		(Month) <u>Feb</u> (Day) <u>8</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>Not known</u>
9. AGE last birthday <u>95</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>daughter Florence Freeman 83450 md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>			
Antecedent cause(s) (b) <u>He was found dead in bed</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>W. Henry Fisher Deputy Med. Exam for 2d Co md</u>		DATE SIGNED <u>2/8-56</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/10/56</u>	<u>Bach Neck</u>	<u>Stevensville md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb. 10, 1956</u>	<u>Elizabeth Hyster</u>	<u>Edgar L. Lane Church St</u>	<u>md</u>

RECEIVED

FEB 14 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2133

CERTIFICATE OF DEATH

02127

Reg. Dist. No. 251

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Templeville</u>		LENGTH OF STAY (in this place) <u>1 Yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Maryland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>		1	
3. NAME OF DECEASED (Type or Print) <u>William H. Kilson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2 22 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6/20/1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kilson</u>				14. MOTHER'S MAIDEN NAME <u>Wilmina Hackett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Albert Kilson Templeville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
421.4 IMMEDIATE CAUSE (A) <u>Organic Heart - (Vascular)</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>21</u> <u>56</u>		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 24</u> , 19 <u>24</u> , to <u>Feb 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/24</u> , 19 <u>56</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edgar D. Lane</u> M.D.				ADDRESS (Street, city, town, state) <u>Goldboro, Md.</u> DATE SIGNED <u>2/23/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		LOCATION (City, town, or county) (State) <u>Marydel, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>2-24</u>		REGISTRAR'S SIGNATURE <u>Edgar D. Lane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulain Greensboro, Md.</u> ADDRESS			

CERTIFICATE OF DEATH

5103

File No. 11

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF CHURCH

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF BURIAL PLACE

20. SIGNATURE OF INTERMENT

21. SIGNATURE OF CREMATION

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

43. SIGNATURE OF OTHER

BUREAU V. S.

FEB 28 1956

RECEIVED

PHOTOGRAPH

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the coroner or other qualified person who has examined the body after death. It should be filled out as soon as possible after death, and should be signed by the person who has attended the deceased or by the coroner or other qualified person who has examined the body. It should be filed with the local health department or with the State Department of Health, Baltimore, Maryland. It is a legal document and its contents are subject to the laws of the State of Maryland.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02128

2134

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Queen Anne</u>		<u>4 years</u>		TOWN <u>Queen Anne</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Joseph Sylvester Kothaneck</u>				(Month) (Day) (Year) <u>Feb 1 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>W</u>	<u>MARRIED</u>	<u>DEC. 31, 1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FArm LABOR</u>		<u>FArm</u>		<u>Austria</u>		<u>Czechoslovakia</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Sylvester Kothaneck</u>				<u>MARIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>214-32-0682</u>		<u>MARY ELIZABETH KOTHANECK</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardio-vascular disease</u>						<u>chronic</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 24</u> 19 <u>53</u> , to <u>Feb 1</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 27</u> 19 <u>56</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Sam Eiders</u>				DATE SIGNED <u>2/1/56</u>			
M.D. <u>Queen Anne Md</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 3-56</u>		<u>Green Mount Cemetery</u>		<u>Queen Anne Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>Feb. 3-1956</u>		<u>Oliver Armstrong</u>		<u>W. Edward Batten & Batten Bros. Centerville Md</u>			

CERTIFICATE OF DEATH

1134

5025

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 45	
DATE OF DEATH Feb 9 1935		PLACE OF DEATH Home		COUNTY Cook	
CITY Chicago		STATE Illinois		ZIP CODE 60611	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	

Copy to file

BUREAU V. S.

FEB 9 1935

RECEIVED

8/11/26

James H. Harris

John 3-16

James H. Harris

NOTICE: This certificate is a record of the death of the person named above. It is not a statement of the cause of death. The cause of death is stated in the space provided for that purpose. The manner of death is stated in the space provided for that purpose. The date of death is stated in the space provided for that purpose. The place of death is stated in the space provided for that purpose. The county is stated in the space provided for that purpose. The state is stated in the space provided for that purpose. The ZIP code is stated in the space provided for that purpose. The occupation is stated in the space provided for that purpose. The signature of the deceased is stated in the space provided for that purpose. The signature of the witnesses is stated in the space provided for that purpose. The signature of the physician is stated in the space provided for that purpose.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2135

CERTIFICATE OF DEATH

Reg. Dist. No.

02129

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL SUDLERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>Rural. SUDLERSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN FRANKLIN PHILLIPS</u>		4. DATE OF DEATH Month Day Year <u>FEB. 28 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 11, 1867</u>
9. AGE (In years last birthday) yrs. <u>88</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>88</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>BENJAMIN F. PHILLIPS</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN CLAYTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wm. C. PHILLIPS - SUDLERSVILLE, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dehydration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>Chronic Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Family</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>W</u> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 1954, to <u>Feb 28</u> 1956, that I last saw the deceased alive on <u>Feb 27</u> 1956, and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. METCALFE</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Sudlersville Md 2/29/56</u>	
PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR 1, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MASSEY CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>MASSEY RENT CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Holloway - Millington, Md.</u>		24a. REC'D BY REGISTRAR <u>3-1</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>

CERTIFICATE OF DEATH

5132

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

MAR 5 1956

RECEIVED

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mostly illegible due to fading and bleed-through.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2136 CERTIFICATE OF DEATH

02140

Reg. Dist. No. 252

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Queen Anne's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Queen Anne's</i>	
CITY OR TOWN <i>Centerville</i>		LENGTH OF STAY (in this place) <i>5 1/2 yrs</i>		CITY OR TOWN <i>Centerville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <i>WINFIELD</i> (Middle) <i>ROE</i> (Last)				<i>July 11 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>December 31-1874</i>	9. AGE last birthday <i>81</i> yrs.	IF UNDER 1 YEAR Months <i>2</i> Days <i>10</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Locomotive Engineer</i>		11. BIRTHPLACE (State or foreign country) <i>Patterson 20th. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel Roe</i>				14. MOTHER'S MAIDEN NAME <i>Ann Katharine Potts</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Esaline S. Roe Centerville Maryland</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Chronic valvular disease of the heart</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1</i> , 19 <i>48</i> , to <i>7/11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>7/11</i> , 19 <i>56</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. H. [Signature]</i>				ADDRESS (Street, city, town, state) <i>Centerville</i>			
DATE SIGNED <i>7/13/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 14-56</i>		NAME OF CEMETERY OR CREMATORY <i>Christ Episcopal</i>		LOCATION (City, town, or county) (State) <i>Centerville Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Glenn Demetrious</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William [Signature]</i>		ADDRESS <i>Centerville Md</i>	
DATE <i>2/13/56</i>							

CERTIFICATE OF DEATH

Decedent's Name
Christine

Place of Birth
Maryland

Age
70

Sex
Female

Marital Status
Married

Place of Death
Baltimore, Maryland

Signature of Physician
J. H. [illegible]

BUREAU V. 2

FEB 17 1936

RECEIVED

Filed for Record
Baltimore, Maryland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2137 CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

02101

251

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sudlersville P 20</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sudlersville P 20</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Elwood J. Walls</u>		4. DATE OF DEATH <u>Feb 21 1968</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec 4-1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-tenant farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Joseph Walls</u>		14. MOTHER'S MAIDEN NAME <u>Ida Walls</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>220-34-9798</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Martha Walls (wife) Sudlersville P 20</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>776x Suicide - Shot himself with a shot gun -</u> Antecedent cause(s) (b) <u>shot gun -</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>W. Henry Fisher M.D. Deputy Med Exam for 2 & Co Mds</u>		ADDRESS <u>Courthouse Md</u> DATE SIGNED <u>2/21-68</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>2-24</u>	
NAME OF CEMETERY OR CREMATORY <u>Double Creek</u>		LOCATION (City, town or county) (State) <u>near Chestertown Ind.</u>	
DATE REC'D BY LOCAL REG. <u>2-21</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	
FUNERAL DIRECTOR <u>Edgar L. Lane - Church Hill, Ind.</u>		ADDRESS	

RECEIVED

FEB 27 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02152

2138 CERTIFICATE OF DEATH

Item 1, Film G192 2-21-56 et

Reg. Dist. No. 252

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Centreville</u>		<u>10 yrs</u>		TOWN <u>Centreville, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Rodanna</u> (First) <u>Walls</u> (Last)				<u>Feb</u> (Month) <u>7</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec. 30, 1864</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housekeeper</u>		<u>Retired</u>		<u>Delaware</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>Wm J. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
<u>no</u>		<u>✓</u>		<u>Mrs L. Callahan Centreville md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic nephritis with heart complication</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/10</u> , 19 <u>54</u> , to <u>2/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Henry Fisher</u>				ADDRESS (Street, city, town, state) <u>Centreville md</u>		DATE SIGNED <u>2/8-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE WHEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Feb. 11, 56</u>		<u>Spring Hill</u>		<u>Easton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2-11-56</u>		<u>Elmer Armstrong</u>		<u>Robert</u>		<u>Easton, Md.</u>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX
4. AGE
5. DATE OF BIRTH
6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH
9. MANNER OF DEATH

10. DATE OF DEATH
11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF BURIAL

17. SIGNATURE OF INTERMENT

18. SIGNATURE OF CREMATION

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

EXPLANATIONS

*For 11:20
Garcia Montano*

2-11-56

RECEIVED
FEB 17 1956
BUREAU V. S.